STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155787	A. BUILDING 00 B. WING	02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA VETERANS HOME	3851 N RIVER RD WEST LAFAYETTE, IN 47906

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F0000	This visit was for the Investigation of Complaint IN00102696. Complaint IN00102696 - Substantiated. Federal/state deficiencies related to the allegations are cited at F282, F314, and F333. Survey dates: February 1 and 2, 2012 Facility number: 001134 Provider number: 155787 AIM number: 200817200 Survey team: Linda Campbell, RN Census bed type: SNF/NF: 167 NCC: 30 Total: 197 Census payor type: Medicare: 2 Medicaid: 136 Other: 59 Total: 197 Sample: 4 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	*This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed 2/7/12 by Jennie Bartelt, RN.			

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F0282 SS=G	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure physician orders were followed prior to a resident's surgery resulting in excessive bleeding during surgery for 1 of 2 residents having had surgery in a sample of 4. (Resident #A). Findings include: Resident #A's clinical record was reviewed on 2/2/12 at 9:30 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, diabetes mellitus, renal insufficiency, congestive heart failure, and amputation of a toe. A "Physician Orders Details" from the wound clinic dated 12/28/11 indicated, "...discontinue Plavix (a blood thinner) and daily aspirin (a blood thinner) now for procedure next Wednesday 1-4-12..." A "Wound Center Evaluation" dated 1/4/12 indicated, "...The patient presents today for planned amputation of the second toe of the left foot. His aspirin and Plavix was to have been put on hold when I called the Indiana Veteran's Home 1 week ago. I was alerted that that did not happen mid through the procedure	F0282	1. What did you do to correct the deficient practice in the residents identified? a. Patient assessed, MD and family notified of the medication continuation beyond stop date, care plans were updated, treatment orders received, and a root cause analysis was done and a Failure Mode Effect Analysis completed.2. What did you do to be sure the deficient practice would not occur with other residents with like diagnoses? a. All residents on those meds with the potiential to cause bleeding and residents in like situations were audited to assure correct orders and care plans updated by RN unit managers.. b. All residents facility wide returning from appointments were audited to assure that all orders were correct and care plans put in place by RN unit managers.3. What systemic changes will you put in place to be sure this does not recur? a. All nurses and QMAs were in-serviced by RN education coordinators, RN unit managers, and RN supervisors on taking off orders with return appointments and admissions. b. All nurses were in-serviced by RN supervisors, RN unit managers on proper checking of 24 hour chart check procedures per policy.4. How	03/01/2012

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	today...Significant time and effort was placed at hemostasis (stopping of bleeding). It took approximately 2 minutes to amputate the foot (sic) and approximately 40 minutes to achieve hemostasis, utilizing Gelfoam (a clotting agent), continued pressure and eventually thrombin (a clotting agent)..." A "Wound Center Evaluation" dated 1/11/12 indicated, "...The patient presents today 1 week status post second toe amputation. He eventually stopped bleeding from his procedure last week. I called the Director of Nurses at Indiana Veteran's Home and chastised her for not having the Plavix and aspirin stopped as I ordered it 1 week prior to the procedure. She checked on the specifics and called me back the next day, admitting fault, that the blame was with Indiana Veteran's Home and communication overall there..." A "Medication Error Report" dated 1/4/12 indicated, "Date of Error: 12/28/11...Name/Dose of Medication: Plavix & ASA (aspirin)...Meds were to be held 12/28/11 through (indicated by arrow) 1/4/12 d/t (due to) surgical procedure - Nurses failed to write...orders...Nurses should have read all orders & transcribed onto sheets. Double check with second nurse..."		will you be sure the changes are monitored? a. Return appointments, admissions, and readmissions will be audited by RN unit managers and RN supervisors as they occur or daily times 30 days, then weekly times one month, then monthly times 3 months, then quarterly thereafter. The results will be reported to QA and trends will be tracked.b. Chart checks will be done daily by the RN supervisors for 60 days, weekly for 30 days, monthly for 30 days, then quarterly thereafter. The results will be reported to QA and trends will be tracked.5. All changes will take place by 3-1-12.	

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	Interview on 2/2/12 at 9:50 A.M. with ADON #1 indicated, "Nurses should be checking orders from the wound clinic." Interview on 2/2/12 at 10:10 A.M. with the Director of Nursing indicated the orders sent back with the resident from the wound clinic were found "in the doctor's drawer." She indicated the nurse on duty "saw the orders but did not transcribe all the orders" from the wound care center sheet. She indicated nurses should have transcribed the orders and the night shift nurse should have double checked the transcription. She indicated the nurses should have known the procedure. She indicated, "You always look for an anticoagulant (a blood thinner) if they're having surgery." Review on 2/2/12 at 10:25 A.M. of a facility policy and procedure, dated 11/08, provided by the Director of Nursing, identified as current, and titled "Physician's Orders/Progress Notes" indicated, "...After 2400 (12 mid night), the nurse or QMA shall check each current physician's order sheet on each chart to ensure that every order is signed, dated and noted correctly...." This federal tag relates to Complaint IN00102696.			

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	3.1-35(g)(2)			

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F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to ensure a resident did not develop pressure ulcers related to accurate assessment, implementing interventions to prevent and providing appropriate treatment for 1 of 3 residents with pressure ulcers in a sample of 4. (Resident #B). Findings include: On 2/1/12 at 8:35 A.M. during an initial tour, the Assistant Director of Nursing #1 indicated Resident #B had a Stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed) on the "left gluteal." On 2/2/12 at 8:15 A.M., with CNA #2 and LPN #3, Resident #B was observed lying in bed in his room. He had a waffle mattress on the bed. The resident was lying on his back. CNA #2 assisted the resident to turn to his left side. The resident was lying on two incontinence	F0314	1. What did you do to correct the deficient practice in the residents identified? a. The resident was assessed, MD and family notified of deficient practice. Care plans, kardexes and aide assignments were updated to reflect any changes by the RN unit manager.b. the chart was reviewed by the RN unit manager and documentation for the area on the right buttocks was in the nurse's note including date of finding, measurement, treatment order and notification by staff nurse. 2. What did you do to assure practice did not occur with like residents? a. All care plans of residents with pressure areas were reviewed and updated facility wide.b. All residents facility wide with pressure areas were checked for proper positioning and proper interventions on kardexes and care plans.c. All charts of residents with wounds were checked to be sure that documentation is done weekly with wound measurements, description, changes, treatments,	03/01/2012

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	pads. There was a transparent dressing on the resident's left buttock. LPN #3 removed the dressing. There was a pressure ulcer present on the resident's left buttock. LPN #3 measured the pressure ulcer as 2.8 centimeters (cm) by 1.4 cm and identified it as a Stage II. LPN#3 left the room to obtain supplies. During her absence CNA #2 sprayed "Perineal/skin cleanser" on a washcloth and washed the resident's buttocks including the pressure ulcer. CNA #2 rolled one incontinence pad and pushed it under the resident, scraping it across the open wound. She placed a clean rolled incontinence pad under the resident. She rolled the resident over the rolled incontinence pads onto the open wound and pulled the incontinence pads through the other side, scraping over the open wound. She then placed the resident on his back with the wound uncovered and waited for LPN #3 to return. Resident #B's clinical record was reviewed on 2/2/12 at 9:05 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, diabetes mellitus, status post colorectal cancer, status post orchiectomy (removal of testes), and Alzheimer's type dementia. A "Braden scale-For Predicting Pressure		and notification if necessary by RN nurse managers. 3. What systemic changes will you put in place to be sure this does not recur? a. Turning and repositioning was added to MAR for nurses to check and sign off on.b. In-servicing was done by RN education coordinators, RN unit managers, and RN unit managers for all nursing staff on positioning, turning properly. Return demonstration is required to pass the in-service. Staff were also in-serviced to follow all instructions as ordered on the kardex and care plan, including positioning orders and instructions.c. In-servicing was done by the RN education coordinators, RN supervisors and RN unit managers for all aides to remind them of their scope of practice .d. RN supervisors will monitor return demonstration 2 times each shift for 4 weeks on aides for turning and repositioning, then 2 times each shift weekly for one month, then 2 times each shift quarterly thereafter and results will be reported to QA for tracking the trends.4. How will you assure changes are monitored? a. TARs will be audited daily times 30 days, weekly times 30 days, then monthly thereafter. Resutls will be reported to QA for tracking trends.b. Supervised audits will take place by RN unit managers and RN supervisors 2 times each shift for 4 weeks, then	

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	Sore Risk" dated 1/8/12 indicated the resident was constantly moist, chairfast, very limited in mobility, had probably inadequate nutrition, and had a problem with friction and shearing. The resident's score was 10, indicating high risk for developing pressure ulcers. A resident care plan, dated 12/5/11, indicated, "...Resident is at risk for skin breakdown d/t (due to) incontinence, needs assist for bed mobility, dx (diagnosis) of DM (diabetes mellitus) and PVD (peripheral vascular disease)...Approach...Turn and reposition during nurse rounds and as needed...pressure reducing mattress and cushion on chair...." A physician's order recapitulation dated January 2012 indicated, "...Rotate off load buttocks every 2 hours...." Physician orders from the wound clinic dated 1/12/12 indicated, "...Keep weight off: buttock. Up for meals only for 30 mins (minutes)...Turn every 2 hours. Avoid direct pressure over wound site..." Nurses' notes indicated: 11/13/11 at 9:00 A.M., "Res (resident) has a skin tear in (L) (left) gluteal crease. 1.2 L (Length) x 0.7 W (width)...Placed		2 times each shift weekly for one month, then 2 times each shift quarterly thereafter and results reported to QA for tracking trends.5. When will changes take place? a. Changes will take place by 3-1-12	

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	on side to relieve pressure..." 11/16/11 at 5:40 P.M., "Seen by wound care team, (L) gluteal area...appears to be from shearing friction. Stage 2..." 11/30/11 at 7:00 P.M., "...(L) gluteal bed is pink & granulating...stage 3..." 12/2/11 at 5:00 P.M., "...noted (L) & right buttox (sic) reddened & excoriated. No drainage from open areas..." 12/13/11 at 10:30 A.M., "...Area to (L) buttock healed. Applied Collagen covered by Allevyn (dressings) then to O/A (open area) on (R) buttock..." 12/21/11 at 1:00 P.M., "...(L) gluteal wound macerated. 0 (no) drng (drainage) noted..." Documentation was lacking related to the right buttock wound. 12/28/11 at 1:00 P.M., "...(L) gluteal area healed..." 12/29/11 at 1:00 P.M. "...orders from wound care (physician name) for lt (left) buttock..." 12/30/11 at 4:30 A.M., "...Drsg (dressing) Collagen c (with) silver c (with) Allevyn then applied to open - non draining area (L) buttock. Allevyn then applied to			

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	reddened non-open area (R) (right) buttocks." 1/8/12 at 12:00 P.M., "Resident noted to have a 2nd open area on (L) buttox (sic) 1.5 x 1.3 wound bed pink. 0 (no) drainage..." 1/10/11 at 10:00 A.M., "...noted 0 (no) dressing to (L) or (R) buttocks...cleansed areas c (with) NS (normal saline). Applied Collagen c (with) silver..." 1/28/11 at 7:30 P.M., "...Drsg (dressing) applied to (L) buttock. Wound bed red. Sm (small) amt (amount) of bloody drainage noted..." 1/30/12 at 5:00 P.M., "...p (after) cleaning noted prior healed wound from 1/28/12 2 areas reopened. #site left gluteal 5 cm x 2cm edges jagged wound bed pink Serosanguinous drainage. 2nd area (L) buttox (sic) above the other wound 1 cm x 1 cm wound bed pink c (with) some scabbing noted..." Weekly Wound Monitoring sheets indicated there were two wound sheets for the "(L) gluteal" which had been identified on 11/13/11. One wound had healed and the other was still open and on 1/25/12 was measured as 0.9 cm x 0.4 cm and was a stage II. Documentation was			

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	lacking related to the wound having been healed or measured since 1/25/12. A Weekly Wound Monitoring sheet dated 1/8/12 indicated, "...(L) buttock 2nd area...Pressure...stage two...Length 1.5 cm...Width 1.3 cm...Depth 0.2 cm..." Documentation indicated the wound had healed on 1/25/12. Documentation was lacking related to the "first area" wound. A Weekly Wound Monitoring sheet dated 1/30/12 indicated, "1/30/12...(L) buttock 2nd site...Shearing...stage two...Length 1 cm...Width 1 cm...Depth < (less than) 0.1 cm..." "2/1/12...macerated...stage two...Length 2.9 cm...Width 1.3 cm...Depth <0.1 cm..." Documentation was lacking related to a "1st site" wound. A resident care plan, dated 1/8/12, indicated, "...Resident has actual skin impairment to...left gluteal...2nd area on Left gluteal 1/8/12...Reposition during nurse rounds and as needed...Up for 30 minutes only for meals...OT (occupational therapy) to pressure map in bed & chair..." Further review of the resident care plan indicated, "...#(1) area (L) gluteal reopened...#(2) area (L) gluteal			

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	reopened..." Documentation was lacking related to any additional interventions implemented to prevent pressure ulcers. Interview on 2/2/12 at 9:20 A.M. with LPN #3 indicated the pressure ulcers on the buttocks had healed on 1/28/12 and reopened on 1/30/12. She indicated they were caused by "shearing." She indicated the "second area is closed. Area #1 is still open. I started a sheet on that one." LPN #3, UM #4, and ADON #1 were unable to locate the wound monitoring sheet for wound #1. Interview on 2/2/12 at 10:10 A.M. with the Director of Nurses indicated, "CNAs should not be washing open wounds." Review on 2/2/12 at 12:55 P.M. of a facility policy and procedure dated 6/8/05, provided the Director of Nursing, identified as current, and titled "Pressure Sore and Wound Management" indicated, "...Preventative measures for residents will be promptly implemented...use only one (1) incontinence pad on the bed...Avoid shearing of skin by use of turn and/or lift sheets when positioning a resident...Progress or lack thereof will be monitored weekly in wound rounds and indicated on weekly wound monitoring form...."			

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	This federal tag relates to Complaint IN00102696 3.1-40(a)(1) 3.1-40(a)(2)			

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F0333 SS=G	The facility must ensure that residents are free of any significant medication errors.			
	Based on interview and record review, the facility failed to ensure a significant medication error did not occur for a resident having surgery, resulting in excessive bleeding during surgery for 1 of 2 residents having had surgery in a sample of 4. (Resident #A). Findings include: Resident #A's clinical record was reviewed on 2/2/12 at 9:30 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, diabetes mellitus, renal insufficiency, congestive heart failure, and amputation of a toe. A "Physician Orders Details" from the wound clinic dated 12/28/11 indicated, "...discontinue Plavix (a blood thinner) and daily aspirin (a blood thinner) now for procedure next Wednesday 1-4-12..." A "Wound Center Evaluation" dated 1/4/12 indicated, "...The patient presents today for planned amputation of the second toe of the left foot. His aspirin and Plavix was to have been put on hold when I called the Indiana Veteran's Home 1 week ago. I was alerted that that did not happen mid through the procedure today...Significant time and effort was placed at hemostasis (stopping of bleeding). It took approximately 2 minutes to amputate the foot and approximately 40 minutes to achieve hemostasis, utilizing Gelfoam (a clotting agent), continued pressure and eventually thrombin (a clotting agent)..." A "Wound Center Evaluation" dated 1/11/12 indicated, "...The patient presents today 1 week status post second toe amputation. He eventually	F0333	1. What correction was made to the resident identified with deficient practice? a. The resident was assessed,MD and family notified of medication continuation beyond the stop date, treatment orders received and care plans updated, root cause analysis was done and a Failure Mode Effect Analysis completed.2. What action was taken to be sure other residents with same problem did not have same occurrence? a. All residents on medications with bleeding potential and like situations were checked for appropriate orders facility wide and care plans were updated by RN unit managers. b. All residents returning from outside appointments and return admissions/new admissions were checked for correct orders facility wide and care plans updated by RN unit mangers.3. What systemic changes will be put into place to assure this error does not recur? a. All nurses and QMAs were in-serviced by RN education coordinators, RN supervisors and RN unit managers on taking off orders properly with new admissions and return appointments. b. All nurses were in-serviced by RN education coordinators, RN supervisors, and RN unit mangers on properly doing 24 hour chart checks per policy. 4.	03/01/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155787	A. BUILDING 00 B. WING	02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA VETERANS HOME	3851 N RIVER RD WEST LAFAYETTE, IN 47906

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	stopped bleeding from his procedure last week. I called the Director of Nurses at Indiana Veteran's Home and chastised her for not having the Plavix and aspirin stopped as I ordered it 1 week prior to the procedure. She checked on the specifics and called me back the next day, admitting fault, that the blame was with Indiana Veteran's Home and communication overall there..." A "Medication Error Report" dated 1/4/12 indicated, "Date of Error: 12/28/11...Name/Dose of Medication: Plavix & ASA (aspirin)...Meds were to be held 12/28/11 through (indicated by arrow) 1/4/12 d/t (due to) surgical procedure - Nurses failed to write...orders...Nurses should have read all orders & transcribed onto sheets. Double check with second nurse..." Interview on 2/2/12 at 9:50 A.M. with ADON #1 indicated, "Nurses should be checking orders from the wound clinic." Interview on 2/2/12 at 10:10 A.M. with the Director of Nursing indicated the orders sent back with the resident from the wound clinic were found "in the doctor's drawer." She indicated the nurse on duty "saw the orders but did not transcribe all the orders" from the wound care center sheet. She indicated nurses should have transcribed the orders and the night shift nurse should have double checked the transcription. She indicated the nurses should have known the procedure. She indicated, "You always look for an anticoagulant (a blood thinner) if they're having surgery." This federal tag relates to Complaint IN00102696. 3.1-25(b)(9) 3.1-48(c)(2)		How will you monitor the changes? a. All audits will be done by the RN unit managers and RN supervisors daily or as admits/appointments occur for the first 30 days, weekly for the next 30 days, monthly for the next 3 months then quarterly therafter. The results will be reported to QA for tracking the trends.b. Chart checks will be audited by the RN supervisor daily for 60 days, then weekly for 30 days, monthly 90 days, then results will be reported to QA for tracking the trends.5. When will changes be done? a. Changes will take place by 3-1-12	

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